

Case Number:	CM14-0034472		
Date Assigned:	06/20/2014	Date of Injury:	06/17/1997
Decision Date:	07/18/2014	UR Denial Date:	02/26/2014
Priority:	Standard	Application Received:	03/19/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Sports Medicine and is licensed to practice in Texas and New York. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 79 year old male who reported an injury on 06/17/1997 due to an unknown injury. There were no complaints reported from the injured worker. Physical examination on 02/14/2014 revealed joint pain with no location documented. Also the injured worker was status post left knee surgery. The report was difficult to read. Medications were not reported. Diagnostic studies were not reported. Physical therapy or physical medicine was not reported. There was notation for the injured worker to continue with stretching and exercises. The treatment plan was for OS4 stimulator unit with supplies. The rationale and request for authorization were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

OS4 stim unit supplies: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Page(s): 114-121. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS (transcutaneous electrical nerve stimulation) Page(s): 114, 115.

Decision rationale: The request for OS4 stimulator unit and supplies is not medically necessary. This is an electrical stimulation device. The most common form is TENS (transcutaneous electrical nerve stimulation), H wave, NMES (neuromuscular electrical stimulation). California Medical Treatment Schedule states not recommended as a primary treatment modality, but a one month home based trial may be considered as a noninvasive conservative option if used as an adjunct to a program of evidence based functional restoration. The request does not state location for use. There is no report of a diagnosis or why this is being ordered, no report of physical therapy or diagnostic studies, no medications reported as tried and failed. Therefore, the request is not medically necessary.